

MEMORIAL HOSPITAL AT GULFPORT
CERTIFICATION BY CUSTODIAN OF MEDICAL RECORDS

STATE OF MISSISSIPPI

COUNTY OF HARRISON

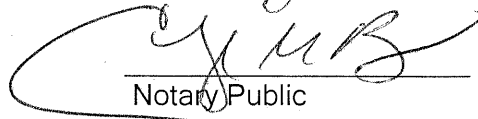
The undersigned being duly sworn does state on oath as follows:

1. That she is the duly authorized custodian of the hospital medical records of MEMORIAL HOSPITAL AT GULFPORT and has the authority to certify records.
2. That the within and annexed are true and correct copies of requested portions from the medical records of CARRUBBA, MARGUERITE, DOB: 09/15/1961 as described in the correspondence received for these records.
3. The within and annexed records were prepared either by the personnel of the hospital or it's staff, physicians or by persons acting under the control either of them, in the ordinary course of hospital business at or near the time of the act, condition or event reported therein.



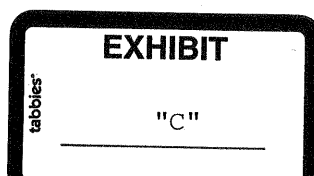
Signature of Custodian

SWORN AND SUBSCRIBED before me, this the 20 day of May 2009



Notary Public

MISSISSIPPI STATEWIDE NOTARY PUBLIC
MY COMMISSION EXPIRES SEPT 8, 2010
BONDED THRU STEGALL NOTARY SERVICE





PATIENT REGISTRATION

MR		PATIENT NAME				ROOM NO		ACCOUNT NO.	
0000018673		CARRUBBA, MARGUERITE A				FC O -		E15 TLA 06168-00189	
PATIENT ADDRESS				CITY				STATE ZIP CODE	
1023 E 2ND ST				PASS CHRISTIAN				MS 39571	
SOCIAL SECURITY NO.	ADMISSION DATE	ADM HOUR	ADM TYPE	ADM SOURCE	ADDD CODE	DISCHARGE DATE	MED SV CD	ADM. PHY	ATT. PHY.
4 [REDACTED]	06/17/06	2247	1	7		ERC ER		999	999
PATIENT PHONE		BIRTHDATE	AGE	SEX	ORIGIN	MARITAL	RELIGION	CHURCH PREFERENCE	
(228) 669-4672		[REDACTED]	44Y	F	4	S	CHR	NO SPECIFIC/CHRISTIAN	
SPOUSE'S NAME			NEAREST RELATIVE				RELATIONSHIP		PATIENT'S MAIDEN NAME
IN CASE OF EMERGENCY NOTIFY			RELATIONSHIP		ADDRESS			CITY	STATE ZIP CODE
CARRUBBA, RICHARD			BROTHER		1023 E 2ND ST			PASS CHRISTIAN	
PRIMARY EMERGENCY PHONE		ALT EMERGENCY PHONE		PATIENT EMPLOYER					
(228) 452-4627				DISABLED					
ADDRESS OF EMPLOYER				CITY		STATE		ZIP CODE	PHONE
NONE				GULFPORT		39501		(228) 000-0000	
OTHER EMPLOYER			ADDRESS						
CARRUBBA, MARGUERITE A									
GUARANTOR EMPLOYER			PHONE		GUARANTOR SOCIAL SECURITY NO.				
DISABLED			(228) 000-0000		428-29-1382				
ADDRESS OF GUARANTOR EMPLOYER			CITY		STATE		ZIP CODE		
NONE			NONE		GULFPORT		MS 39501		
ALLEGED ASSULT			ACCIDENT		DATE		TIME		
NAME OF INSURANCE NO. 1			NAME OF INSURANCE NO. 2			NAME OF INSURANCE NO. 3			
MEDICARE			MEDICARE 1500 FORM			MEDICAID SECONDARY			
GROUP NAME			GROUP NAME			GROUP NAME			
GROUP NO. / POLICYHOLDER			GROUP NO. / POLICYHOLDER			GROUP NO. / POLICYHOLDER			
CARRUBBA, MARGUERITE A			CARRUBBA, MARGUERITE A			CARRUBBA, MARGUERITE A			
[REDACTED]			[REDACTED]			601603411			
STREET ADDRESS			STREET ADDRESS			STREET ADDRESS			
MEDICARE			MEDICARE			MEDICAID			
PO BOX 23035			PO BOX 23035			PO BOX 23077			
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE	
JACKSON	MS	39225	JACKSON	MS	39225	JACKSON	MS	39225	
Admitting Diagnosis (Record here or on Physical Examination)									Days
PRINCIPAL Diagnosis									Codes
Complications and/or Additional Diagnosis (List All)									
Principal Procedure									
All Other Procedures									
PRINTED BY: slh9337									
DATE 5/18/2009									
Consultation with									
<input type="checkbox"/> ALIVE <input type="checkbox"/> AMA <input type="checkbox"/> DIED <input type="checkbox"/> TRANSFER (AUTOPSY <input type="checkbox"/> YES <input type="checkbox"/> NO)									



13408

CONSENT FOR ADMISSION TO HOSPITAL AND MEDICAL TREATMENT

I, X Myself, give permission for such examination and treatment as the doctor(s) considers necessary or advisable for the care of CARRUBBA, Marguerite A (Patient's Name).

I understand:

1. That examination and treatment may include x-rays, drawing blood, medical/surgical care, medicines, anesthesia, or other healing measures.
2. That unexpected situations may arise and I now give permission, in the event I am later unavailable or unable to consent, for the doctor(s) to do what is necessary to save the health, or life, of the above named patient.
3. If I/the above named patient deliver a baby during this hospital stay, I give permission for such examination and treatment of that baby as the doctor(s) considers necessary and advisable.
4. The practice of medicine and surgery is not an exact science. There are no guarantees of success.
5. I have read and do understand this consent. I have had a chance to ask questions. The MHG staff answered my questions.

CONSENT TO RECORDING OR FILMING

I consent and authorize Memorial Hospital at Gulfport (including, but not limited to, its agents, servants, employees, staff members and volunteers) to make, maintain and use photographic, video, electronic/computer or audio media to document my condition or treatment for the purpose of identification, diagnosis and care and to exhibit, publish, televise or otherwise show said media for educational, performance improvement and related purposes and to permit others to do the same. I understand that there is a possibility that I may be identifiable in these media though my name will not be published unless I specifically authorized same in writing. I understand that I have the right to request cessation of the recording and filming and to revoke this consent by providing a written request/notice to the hospital Health Information Management Department at least twenty-four (24) hours before the media is used.

OTHER TERMS OF ADMISSION

I understand:

1. Memorial Hospital at Gulfport will send me/the above named patient a bill.
2. Each physician specialist who examines or treats me or the above named patient will send a separate bill.
3. I am responsible for calling my insurance company before admission. The insurance company may reduce my benefits if I do not follow procedures. The hospital will contact the insurance company only as a courtesy.
4. If I am in a Managed Care Plan requiring approval of a primary care physician (PCP), the hospital will contact the PCP for instructions. My insurer may not pay if I receive services without their approval. In this case, I may be personally responsible for all charges for these services.
5. Memorial Hospital will not deny or delay treatment for any emergency medical condition in order to contact or receive approval from my insurance company or any PCP.

WAIVER OF CLAIM FOR LOSS OR DAMAGE TO PERSONAL PROPERTY

I understand:

1. I may place my personal property in the Hospital safe.
2. I am responsible for loss of or damage to personal property that I do not place in the Hospital safe.

Witness

Adams

Time

2242

X Marguerite Carrubba Date JUN 17 2006
Signature of patient or person permitted to sign for patient

Date

JUN 17 2006

2899 (4/06)

Consent for Admission
to Hospital and
Medical Treatment
PRINTED TO THE HOSPITAL
DATE 5/18/2009

CARRUBBA, MARGUERITE A

PHYSICIAN, E R

06/17/2006

MR 0000018673

DOB [REDACTED]



ERC F 44Y

0616800189

CONSENT FOR ADMISSION TO HOSPITAL AND MEDICAL TREATMENT AUTHORIZATION TO RELEASE INFORMATION TO INSURER & ASSIGNMENT

I give permission to the Hospital to release medical information needed to process any claim related to this hospital stay against any of my insurance companies including automobile or other liability insurance companies. MHG can release this medical information only to the insurance company or any third party payor involved in this claim. Third party payors may be Medicare, Medicaid, CHAMPUS, CHAMPVA, automobile or other liability insurance, or any worker compensation plan. This permission is good for the time provided in MHG's Health Information Management Department policy unless I deliver to the Hospital written notice of cancellation.

I assign all insurance benefits and all third party claims up to the amount owed to Memorial Hospital at Gulfport and to any physicians who provide services to me or the above named patient. I direct third party payors to pay all benefits directly to MHG and these physicians.

I have given current and correct information about my insurance or other benefit status to the Hospital.

Witness Adams

X Marguerite Carrubba Date JUN 17 2006
Signature of patient or person permitted to sign for patient

Date JUN 17 2006

FINANCIAL AGREEMENT AND GUARANTY OF PAYMENT

In consideration of services rendered the above named patient, I unconditionally guarantee payment for services not covered by insurance or a benefit program while a patient in Memorial Hospital at Gulfport. I guarantee this payment within 60 days of final billing. If I do not pay in full, within that time, MHG may refer the bill to an attorney or collection agency. If the bill is referred to an attorney, either by MHG or by a collection agency, I will be responsible for attorneys' fees of up to 33 1/3% in addition to the amount of the bill and legal interest from date 60 days after final billing. I understand that the Hospital has the right to examine credit bureau files for financial information on unpaid debts. MHG may inform any credit bureau if any hospital bill not paid within 60 days of final billing.

I have read and understand this financial agreement. I have had a chance to ask questions. The MHG staff answered my questions.

Witness Adams

X Marguerite Carrubba Date JUN 17 2006
Signature of Patient or Guarantor of Account

Date JUN 17 2006

Self Relationship to Patient

PATIENT IS UNABLE TO CONSENT TO THE FOREGOING OR IS A MINOR, COMPLETE THE FOLLOWING:

PATIENT IS A MINOR _____ YEARS OF AGE / PATIENT IS UNABLE TO CONSENT BECAUSE _____
JUN 17 2006

Witness _____

Signature of patient or person permitted to sign for patient

Date JUN 17 2006

Important Message from Medicare received: _____
Signature of Patient

Clerk Initials _____ Date JUN 17 2006

PRINTED BY: slh9337
DATE 5/18/2009

CARRUBBA, MARGUERITE A
PHYSICIAN, E R 06/17/2006
MR 0000018673 DOB
ERC F 44Y
0616800189



CP4



Name Carrubba Marguerite		DOB 9-15-61		Age	
Triage Level 3	<input type="checkbox"/> Emergent Priority	<input type="checkbox"/> Urgent Priority	<input checked="" type="checkbox"/> Non-Urgent Priority	Emotional Status: <input type="checkbox"/> Comatose <input type="checkbox"/> Calm <input type="checkbox"/> Adv. Directive <input type="checkbox"/> Anxious <input type="checkbox"/> Combative <input type="checkbox"/> Cooperative <input type="checkbox"/> Living Will <input type="checkbox"/> Hostile <input type="checkbox"/> Other: <input type="checkbox"/> DNR <input checked="" type="checkbox"/> NONE	
<input type="checkbox"/> 24-72 Hour Return	On the Job Accident: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Mode of Arrival: <input checked="" type="checkbox"/> W/C <input type="checkbox"/> Ambulatory <input type="checkbox"/> Carried <input type="checkbox"/> Ambulance		Arrived With: <input type="checkbox"/> Friend <input type="checkbox"/> Self <input type="checkbox"/> Yes: <input type="checkbox"/> Ice <input type="checkbox"/> IV <input type="checkbox"/> ACLS <input type="checkbox"/> Police <input type="checkbox"/> Spouse <input type="checkbox"/> O/2 <input type="checkbox"/> Spine Board/C-Collar <input type="checkbox"/> Monitor <input type="checkbox"/> Relative <input type="checkbox"/> Parent <input type="checkbox"/> Splint/dressing <input type="checkbox"/> Other	
<input type="checkbox"/> Same Complaint	Date: 2005 4/4/6	Time of Event:		Treatment Prior to Arrival: <input checked="" type="checkbox"/> None <input type="checkbox"/> ACLS	
<input type="checkbox"/> New Complaint	Visual Acuity RT20/ 2005 LT20/ 4/4/6 Both20/ 140 53"	TET Tox 4/4/6 Wt. 140 Ht. 53"		TB Screen <input type="checkbox"/> Persistent Cough > 2 weeks <input type="checkbox"/> Wt Loss <input type="checkbox"/> Hx of TB <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Anorexia <input type="checkbox"/> No Symptoms <input type="checkbox"/> In Foreign Country Recently	
<input type="checkbox"/> Call Back	Date 6-17-06 Time 2240	Chief Complaint: (In Patient's Words) 96 assault @ Jail		PAIN ASSESSMENT <input type="checkbox"/> None <input type="checkbox"/> Pt Uncooperative <input type="checkbox"/> Unable to assess due to acuity	
RN Signature [Signature]		Pain now: (circle) 2			
Private Physician(s): Tanner		For PEDS, use faces scale; document as 0-10.			
<input type="checkbox"/> STAT (ED) Placement to Room # WU					
<input type="checkbox"/> Reported to WU		How long have you been in pain? 5 min			
<input type="checkbox"/> To Lobby after triage - Awaiting Bed Availability		Location(s) (specify each site) Left wrist			
<input type="checkbox"/> To Room # WU at WU		<input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input checked="" type="checkbox"/> Other bruise			
<input type="checkbox"/> Report to WU		What worsens pain? None			
<input type="checkbox"/> LWBS at WU		What relieves pain? None			
<input type="checkbox"/> Refusal Obtained		Pain interferes with: <input type="checkbox"/> Function <input type="checkbox"/> Sleep <input type="checkbox"/> Appetite <input type="checkbox"/> Other			
Social History: <input type="checkbox"/> Lives - <input type="checkbox"/> Alone <input type="checkbox"/> N.H. <input type="checkbox"/> Family <input type="checkbox"/> Homeless		Past Surgical History: Back			
<input type="checkbox"/> Smoker - <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> PPD 11/11		Past Medical History:			
<input type="checkbox"/> ETOH Use - <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Initial Vitals			
<input type="checkbox"/> Abuse - <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		BP 144/58			
Family Patient		<input type="checkbox"/> NIBP			
<input type="checkbox"/> Family	<input type="checkbox"/> Patient	<input type="checkbox"/> Audible			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Palpable			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung Disease	Pulse 116			
<input type="checkbox"/> Cancer	<input type="checkbox"/> COPD	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular			
<input type="checkbox"/> CVA	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Weak			
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nerves	Resp 22			
<input type="checkbox"/> GI	<input checked="" type="checkbox"/> Back Problems	<input type="checkbox"/> Regular <input type="checkbox"/> Shallow			
<input type="checkbox"/> Ulcer	<input type="checkbox"/> Seizures	<input type="checkbox"/> Labored			
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> PVD	Temperature 77.6			
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mental	<input type="checkbox"/> Oral <input type="checkbox"/> Rectal			
<input type="checkbox"/> Angina	<input type="checkbox"/> Renal	<input type="checkbox"/> Axillary			
<input type="checkbox"/> CAD	<input type="checkbox"/> Thyroid	SpO2 <input type="checkbox"/> Room Air			
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> None	<input type="checkbox"/> O/2 at 100%			
<input type="checkbox"/> HIV					
Comments: Wt 150 lbs		ALLERGIES <input checked="" type="checkbox"/> NONE KNOWN			
offered 225 mg		Food, Medication, Latex, Tape, Iodine, Other			
Wt 150 lbs		Rash Hives Dyspnea N/V Other			
Wt 150 lbs		1. [Signature]			
Wt 150 lbs		2. [Signature]			
Wt 150 lbs		3. [Signature]			
Special Needs or Physical Ability Needs		Mental Status			
<input type="checkbox"/> N/A	<input type="checkbox"/> Blind Y/N Interpreter	<input checked="" type="checkbox"/> Alert <input type="checkbox"/> Uncooperative			
<input type="checkbox"/> Foreign language Interpreter	<input type="checkbox"/> Deaf Y/N Interpreter	<input checked="" type="checkbox"/> Oriented X 3 <input type="checkbox"/> Combative			
	<input type="checkbox"/> Financial	<input type="checkbox"/> Lethargic <input type="checkbox"/> Drowsy			
	<input type="checkbox"/> Emotional	<input type="checkbox"/> Unresponsive <input type="checkbox"/> Disoriented			
	<input type="checkbox"/> Spiritual	Skin Color			
	<input type="checkbox"/> Cultural	<input checked="" type="checkbox"/> Normal Pink <input type="checkbox"/> Ashen			
		<input type="checkbox"/> Dark Pigment			
		<input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed			
		<input type="checkbox"/> Pale <input type="checkbox"/> Jaundiced			
		Speech			
		<input checked="" type="checkbox"/> Coherent <input type="checkbox"/> Incoherent			
		<input type="checkbox"/> Slurred <input type="checkbox"/> Silent			
		Skin Temp			
		<input checked="" type="checkbox"/> Warm <input type="checkbox"/> Hot			
		<input type="checkbox"/> Dry <input type="checkbox"/> Moist			
		<input type="checkbox"/> Diaphoretic			
		Respiratory			
		<input checked="" type="checkbox"/> Regular <input type="checkbox"/> Labored			
		<input type="checkbox"/> Shallow <input type="checkbox"/> Retractive			
		<input type="checkbox"/> Absent			
		Pupils			
		<input type="checkbox"/> N/A <input checked="" type="checkbox"/> Equal			
		<input type="checkbox"/> RT <input type="checkbox"/> LT			

Memorial
Building a Healthier Community

Emergency
Department
Nursing
Record

PRINTED BY: **51h9337**
DATE: **5/16/2009**

PATIENT INFORMATION

CARRUBBA, MARGUERITE A
PHYSICIAN, E R
MR 0000018673
06/17/2006
DOB **[Redacted]**
ERC F 44Y
0616800189

Account #

Date: _____

Time	T	P	R	BP	Time	T	P	R	BP

CARRUBBA, MARGUERITE A
 PHYSICIAN, E R
 MR 0000018673
 06/17/2006
 DOB [REDACTED]
 ERC F 44Y
 0616800423

2240 Dec 1st @ 4:30 alleged assault early A.M. Prisoner noted
 (C) arm slight swelling to lips noted. Pt stated she taken her marks Pt A
 Wellbourn, officer & nurse & vet. Pt agitated & jumpy now. - Hollman
 2315 Xanax .5mg 10 given for agitation. Family @ bedside. - Hollman 2320
 to X - very vain structure. - Hollman 2345 Sheriff dept could not come
 make a report of alleged assault. - Hollman 0010 Sec 1 called
 back from Sheriff office stated pt had made reports earlier today
 and they weren't sent any are also sent to take another. Pt to see
 Steve Campbell & Sheriff office. - Hollman 0025 Discharge instructions
 given. Family & patient requested 4 witnesses then take picture. I informed
 pt that witness would be unnecessary because origin of bruising
 can't be determinant since alleged incident happen several hours ago
 plus she also had car accident. Bruise (C) arm purplish forearm & red
 on (C) wrist area & slight reddness to lip & chin area. Tylenol 325mg 10
 given. Pt / Pt verbally understood instructions given.
 - Hollman

[illegible][illegible]

Disposition	<input type="checkbox"/> Admitted Time	Room No.	Ready Room Time	<input checked="" type="checkbox"/> Discharged Via	<input checked="" type="checkbox"/> Ambulatory	<input type="checkbox"/> Wheelchair
0030 AM/PM			PRINTED BY: slh9337	<input type="checkbox"/> In Arms	<input type="checkbox"/> Ambulance	

HISTORY, AND PHYSICAL		Time: 2257	FMH:		*4000A*	
CC/PHI:		SH: +				
Analyzed This AM. Tachy white in front regional anesthesia by Switzer. Thrown on ground. Bumped on wrist & chin Regained consciousness after 10 min (wound) & arm cuff & smacked her face into floor. No neck soreness 1 on back. L2/L3 Bulky.				ROS: • if neg. Gen: 0 Card: 0 @ Resp: 0 Renal: 0 End: 0 GI: 0 Neuro: 0 Eye: 0 ENT: 0 Skin: 0 Psych: 0 Ms/Stl: 0		
Post BK, Neck Pain NK Surgery x 5, BK Surgery Heard @				ORDERS		
Exc. After Surgery VS & T file. Fresh Bruise to @ Chin. Both wrists. Left dorsal hand. Left dorsal forearm wound on face on scalp on neck on back on arm can see 5 min. all gone. Refuse				Test Order Tm/Int. Rx Spine Rx Spine		
LAB:		X-RAY old change EKG U.S./C.T.		Nurse Order Tm/Int. X-ray 0.5 hr Tylenol 325 5 pm		
DIAGNOSIS: Multiple Bruise						
<input checked="" type="checkbox"/> May Discharge <input type="checkbox"/> Admit Time		<input type="checkbox"/> Transfer <input type="checkbox"/> AMA Condition on Discharge <input checked="" type="checkbox"/> Stable		I HAVE REVIEWED THE NURSES ASSESSMENT AND HISTORY Physician's Signature [Signature] <input type="checkbox"/> See Dictated Notes		
Patient Instructions <input type="checkbox"/> Sprain & Fracture, Severe Bruises <input type="checkbox"/> Medications <input type="checkbox"/> Head Inj (adult) <input type="checkbox"/> Fever <input type="checkbox"/> Back/Neck Inj <input type="checkbox"/> Vomiting/Diarrhea <input type="checkbox"/> Common Cold/Viruses <input checked="" type="checkbox"/> Sedation Instruction <input type="checkbox"/> Reducing High Fever <input type="checkbox"/> Orthopedic Appliance <input type="checkbox"/> Head Inj (Child) <input type="checkbox"/> Eye Inj <input type="checkbox"/> Wound Care/Animal Bite <input type="checkbox"/> Burns <input type="checkbox"/> Other						
DISCHARGE INSTRUCTIONS: OTC Pain Med						
Follow Up <input type="checkbox"/> Make an appointment to see your regular physician <input type="checkbox"/> Follow-up Visit in Emergency Department <input type="checkbox"/> Have Sutures Removed in Days						
Patient/S/O VERBALIZED UNDERSTANDING OF INSTRUCTIONS Nurse Signature [Signature]			I HAVE READ AND UNDERSTAND AND INSTRUCTIONS AND HAVE RECEIVED A COPY OF THEM Patient Signature [Signature]			



**Emergency
Department
Physician
Record**

PRINTED BY: slh9337
DATE 5/18/2009

CARRUBBA, MARGUERITE A
PHYSICIAN, E R
MR 0000018673
DOB [REDACTED]
ERC F 44Y
0616800189

CARRUBBA, MARGUERITE A DOB: [REDACTED] AGE: 44Y
MR# G0000018673 CI# 927005 ACCOUNT # 0616800189
SERV: ERC
PT TYPE: ERC LOC: DIS - ERC EXAM DATE: 06/17/06
ORD: LEVIN, PHILIP MD ADM: PHYSICIAN, E R MD
ATT: LEVIN, PHILIP MD

Chk-in #	Order	Exam
927005	0001	10648 XR SPINE CERVICAL AP&LAT
		Ord Diag: alleged assault

CERVICAL SPINE, FOUR VIEWS:

CLINICAL INFORMATION INCLUDES: Alleged assault. Neck and back pain.

The patient has had multi-level cervical fusion. There is degenerative narrowing of the C3-4 interspace with prominent endplate osteophytes. C4-C7 levels appear fused. There are internal fixation plates anteriorly at C3-4 and at C7-T1. Odontoid process appears to be intact. No abnormal prevertebral swelling. Similar imaging appearance noted on earlier MRI study on 05/01/06.

IMPRESSION:

ANTERIOR CERVICAL FUSION AT C4-T1. DEGENERATIVE CHANGES AT C3-4 ENDPLATES. NO ABNORMAL SUBLUXATION OR SPECIFIC ACUTE ABNORMALITY IS SEEN RADIOGRAPHICALLY.

Read By- F A LOVELL , M.D.

Released By- F A LOVELL , M.D.

Released Date Time- 06/18/06 0949

Typed By- JJS

PRELIMINARY UNLESS RELEASED

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: slh9337

DATE 5/18/2009

CARRUBBA, MARGUERITE A DOB: [REDACTED] AGE: 44Y
MR# G0000018673 CI# 927006 ACCOUNT # 0616800189
SERV: ERC
PT TYPE: ERC LOC: DIS - ERC EXAM DATE: 06/17/06
ORD: LEVIN, PHILIP MD ADM: PHYSICIAN, E R MD
ATT: LEVIN, PHILIP MD

Chk-in # Order Exam
927006 0002 10654 XR SPINE LUMBAR AP&LAT
Ord Diag: alleged assault

LUMBAR SPINE, THREE VIEWS:

CLINICAL INFORMATION INCLUDES: Alleged assault. Neck and back pain.

The lumbar curvature is normal. There is moderate narrowing of the L5-S1 disc interspace. Vacuum disc at L5-S1. Mild narrowing at L4-5 interspace. There is no compression fracture or abnormal subluxation recognized. Symmetric SI joints.

IMPRESSION:

MODERATE L4-5 AND MILD L3-4 DISC INTERSPACE NARROWING. VACUUM DISC AT L5-S1. NO SPECIFIC ACUTE ABNORMALITY IS SEEN RADIOGRAPHICALLY.

Read By- F A LOVELL , M.D.

Released By- F A LOVELL , M.D.

Released Date Time- 06/18/06 0949

Typed By- JJS

PRELIMINARY UNLESS RELEASED

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: slh9337

DATE 5/18/2009



INTERDISCIPLINARY PATIENT/FAMILY EDUCATION FLOW SHEET

INITIAL	PROVIDER SIGNATURE	INITIALS	PROVIDER SIGNATURE
<i>20</i>	<i>Kulbarn</i>		

DOCUMENTATION LEGEND:

Topic				
M - Medications	P - Procedure	D - Diet	A - ADL	FDI - Food/Drug Interaction
E - Equipment	C - Consents	DX - Diagnosis	T - Treatment	Other _____
Readiness to Learn				
Ability to Understand Verbal Instruction:	VP - Poor	VA - Average	VG - Good	
Cognitively Able to Understand:	CP - Poor	CA - Average	CG - Good	
Ability to Understand Written Instruction:	WP - Poor	WA - Average	WG - Good	
Barriers to Learning				
P - Physical	V - Visual	C - Cognitive	M - Motivation	R - Religious
R - Reading	L - Language	CL - Cultural	AR - Age Related	E - Emotional
A - Auditory	N - None			
Who				
PT - Patient	F - Family	O - Other		
Learning Method Used				
D - Demonstration	TV - Video/TV/Audio	W - Written	GR - Group Work	
P - Pamphlet	V - Verbal Instruction	MED - Medication Instruction Sheet	O - Other	
Comprehension				
1. Verbalized or demonstrated understanding.	4. Medical condition limits understanding.			
2. Not receptive/cooperative.	5. _____			
3. Needs further instruction.	6. _____			

DATE/ TIME	PROVIDER INITIAL	TOPIC	READINESS TO LEARN	BARRIERS TO LEARNING	WHO	LEARNING METHOD USED	COMPREHENSION	PREFERRED LEARNING METHOD:
								INFORMATION TAUGHT
4/17/06 2315	2	M	VA	N	P/H	V	1	Verbal
0230	2	T	VA	N	P/H	V	1	Return of needed
0530	2	T	VA	N	P/H	V	1	OTC pain meds



Interdisciplinary
Patient/Family
Education Flow sheet

PRINTED BY: 5142337
DATE: 5/15/2009

PATIENT INFORMATION

ERC -
CARRUBBA, MARGUERITE A
06/17/2006 MR 0000018673
PHYSICIAN, E R
DOB [REDACTED] 0616800189
F 44Y

